

Co-operation with family members
– a challenge for Registered Nurses in
community elder care

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ABSTRACT

Co-operation with family members – a challenge for Registered Nurses in community elder care

The overall aim of this thesis was to gain knowledge of how Registered Nurses (RN) are able to work together with family members of older people living in community elder care facilities.

A questionnaire was distributed to all RNs (N= 314) with permanent appointments in community elder care in one province, and 67 percent (n = 210) answered after two reminders (**I**, **II**). The age of the participants was from 23 to 64 years and half of the participants worked in urban areas. About half of the participants had experience of work in elder care of five years or more.

Study **I** focused on the RNs view of co-operation with family members of the old person and what influenced that co-operation. The working situation for RNs in community elder care showed that nearly half, 46 % of the RNs were not satisfied with their working situation. It was the nurses with more than five years of working experience that were unhappy with their working situation. The limited organisational and personnel resources influenced their ability to co-operate with the family members. The RNs expressed dissatisfaction and frustration when they could not spend enough time caring for the old people or communicating with their family members. The RNs believed that it was important for family members to show their involvement in the care of the old person. The results showed that co-operation would be more complicated if there was a conflict of interest between the RN and the family member. Furthermore, the RN pointed out the importance of family members taking care of the older person's interest.

Study **II** focused on what the RNs described as positive, negative or problematic in their co-operation with family members of old people. Content analysis was used in the analysis of the three open-ended questions. Three themes emerged from the answers of the three open-ended questions, namely *Problems within the system*, *Interaction with families* and *Caring in nursing work*. The co-operation between the RN and the family member was especially important when the old person was suffering from dementia. An exchange of information about the person before illness was especially important as it was then possible to provide better care and understanding for the old person.

The development of community elder care will put increasing demands on the RNs in community elder care in the future and there is a need for further support and guidance. Her working situation involves both working alone and being a part of a team. Informal care giving is also expected to increase as the elder population increases and by that the registered nurse will be even more important in community elder care as more persons are dependent on her competence. Conclusions drawn imply that the RN in community elder care is dependent on the organization of elder care and the organization is dependent on RNs competence.

Keywords: registered nurse, elder care, co-operation, family members, job satisfaction, communication, descriptive statistics, content analysis.

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ORIGINAL PAPERS

- I** Weman K, Kihlgren M, & Fagerberg I. (2004) Older people living in nursing homes or other community care facilities: Registered Nurses' views of their working situation and co-operation with family members. *Journal of Clinical Nursing* **13**, 617-626.
- II** Weman K & Fagerberg I. Registered Nurses working together with family members of older people. *Journal of Clinical Nursing*, In Press.

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INTRODUCTION

Demography

The population of older people in Sweden is increasing as in the rest of the western world. As a result levels of physical and mental health amongst the elder are also changing. There is an ongoing discussion as to whether these changes will lead to a reduction or an increase in or a postponement of morbidity. It is therefore important to follow health trends amongst the older people in order to adapt to the forthcoming needs for their medical and social care. (Agahi *et al* 2004).

The number of people aged 65 or older in Sweden was 17.2% in 2003. Only three countries out of 44 in Europe, namely Greece, Germany and Italy, have an older population than Sweden. During the last twenty years the group of people aged 80 or older has increased by 81 %, 263,000 to 476,000 (Statistics Sweden 2005) and the cost of providing for these older people has posed an economic problem for local communities and the government. The number of people 90 years or older is expected to increase to 35% of the population. (Statistics Sweden 2005, The National Board of Health and Welfare 2004). About 50% of the population aged 80 or older is living singly and the majority of them are females (Agahi *et al* 2004, Winqvist 1999).

From the 1950s the number of immigrants increased, peaking in the 1980s, and then declined in the 1990s. The number of elder people originating from other countries is about 5 %, and they are mainly from the other Nordic countries (Heikkilä 2004). As a result new demands are placed on those responsible for the care of the elder immigrant population (Agahi *et al* 2004, The National Board of Health and Welfare 2004).

The old person

The older persons often suffer from multiple diseases and the need for well-trained and competent staff is essential in their care. People suffering from dementia and older people that have immigrated to Sweden from other countries are known to be especially vulnerable, when they move from a familiar environment into other facilities, like emergency wards or sheltered housing (Kihlgren 2005, Sandberg *et al* 2001). Professional carers have to bear in mind the individual's integrity and independence and have to deal with ethical issues as they arise. The family members are important for the exchange of information, especially when the old person is not capable of making decisions or speaking for themselves (Plowfield *et al* 2000, Shyu 2000).

Family members to the old person

The situation for family members can vary, and if the family member is a spouse his or her age and state of health will affect their ability to take responsibility for caring (Plowfield *et al* 2000). In the case of children the ability to care for a parent can be limited by practical factors such as not living nearby, their work, or their own family situation. Relationships within the family, both past and present, can also affect how well one can care for an old relative (Plowfield *et al* 2000). It is more common that female rather than male relatives take responsibility for the care of the old (Plowfield *et al* 2000, Seaward 1999, Winqvist 1999) Several studies show that family members want to help with the care of their relatives (Hellström 2005, Hetzberg 2002, Sandberg *et al* 2001, Almberg 1999, Andershed 1998) and that they appreciate when they receive information about the old person's situation and are able to participate in planning their care. Different methods have been used to facilitate the participation of informal caregivers and family members (The National Board of Health and Welfare 2005c, The National Board of Health and Welfare 2000).

Elder care in the community

Care of old people in Sweden was reorganised in 1992 when the local community was made responsible for providing medical care and home care service (The National Board of Health and Welfare 2005a, Gurner & Thorslund 2003). The ultimate aim was that old people should be able to stay in their own homes to the end of their life, and receive care and service from the community when needed.

Generally the social services, including the care of the elder, are responsible for the administration of care for people who need help and support in a municipality. The manager for social services in the community is not required to have a formal nursing education and Registered Nurses (RNs) are employed in community elder care or in primary health care. The Home Care Service (HCS) are responsible for housing and the community health service has responsibility for providing caring and nursing (Theobald 2003, Westlund & Larsson 2002, Lundström & Ehnfors 2001, SFS 2001:453, SOSFS 1997:14). Usually one member of the staff is selected as a 'contact person', to take care of practical issues for the old person when family members are not nearby.

According to the directive (SOSFS 1997:10), each municipality must be able to offer medical service up to the level of an RN (The National Board of Health and Welfare 2005d, Westlund &

Larsson 2002,). In each municipality a medical responsible nurse (MAS), appointed to have responsibility for the development and the quality of care for older people.

The reorganization meant that hospitals were able to considerably reduce their number of beds by 55 % (from 56,000 to 26,000) in the period 1992 to 2003 (The National board of Health and Welfare, 2005a). In addition, hospital care is provided for a shorter period of time and the community health care services have to provide care for a group of patients with extensive medical needs. This has led to increasing demands on the competence for the RN in community elder care. More people with illness and health problems will be cared for in sheltered housing facilities and ordinary homes of the old person (Szebehely 2000).

Annual reports from the communities

A glimpse of the recent changes taking place in 7 out of 12 communities in one county of Sweden was presented in annual reports from 2001 – 2002 (Annual reports 2000/2001) and showed that care and nursing for the old people in the community were in a process of development and change. The old person was mostly in a poor state of health and the task of rehabilitation was to a large extent the responsibility of staff in the community.

The community was responsible for organizing the care of the older persons round-the-clock. The community health care services were asked to take a holistic approach when providing care for their elder. Several reports indicated the increasing need for special facilities for people suffering from dementia, for younger people suffering from dementia in combination with alcohol addiction, for care of persons with mental illness and for palliative care. Furthermore, the annual reports reported problems retaining competent RNs within the organisation and indicated that there may be difficulties appointing professional carers in the future. The need for further education in different specialisations was also pointed out.

Support for family members was provided in the form of special courses and the chance of a short stay in hospital or equivalent facilities, in order to relieve the pressure on the informal caregiver and/or family member (Annual reports 2000/2001).

The role of the RN in the community elder care

The working situation for nurses in elder care is complex and there are many aspects that affect their ability to manage that situation. The importance of having trust in the role as nurse in elder

care is essential (Gustafsson & Fagerberg 2004, Kihlgren *et. al.* 2003, Tunedal & Fagerberg 2001, Travelbee 1971).

The work consists of nursing and caring for the old person. Health care including rehabilitation and prevention are important parts in the care of the old person (SFS 1982:763). Care planning is carried out together with other professionals such as social service officers, occupational therapists, physiotherapists, physicians, staff and family member of the old person (Westlund & Larsson 2002).

Decision-making is important during their work and the nurse can work alone or have colleagues to discuss problems with (Fagerberg 1998). Besides this, the work consists of social contact with other professionals and community services departments, medical care and treatment and administration (The National Board of Health and Welfare 2005d, Westlund & Larsson 2002).

The RNs' responsibility during daytime hours can include care at from one to several wards at sheltered housing facilities. At weekends and at night she may also have responsibility for people residing in their ordinary homes within a prescribed area. This may mean being responsible for up to 500 persons in an area (Kihlgren 2005). Because the old person is assigned to a doctor and depending on the number of older persons the nurse is responsible for, the RN has to make contact with several doctors. In daytime the RN can contact either a doctor at the local Primary Health Care Centre (PHCC) or the old person's private doctor. In sheltered facilities a geriatrician can be contacted, and at night and weekends contact will be made with the doctor in charge at the emergency ward. This procedure may cause problems for the RNs and the old person because the doctor on call will not have the patient's history. In addition, the documentation is logged on two separate records, one for the doctor and one for the caring and nursing staff. The professionals will not have immediate access to each other's documentation and the quality of care will thus be jeopardized when action is taken for the old person (The National Board of Health and Welfare 2005b).

There is no requirement for specialist training to work in community health care for old people, but there is a wish that nurses should have experience of caring work in a hospital before working in community elder care (Tunedal & Fagerberg, 2001). It is regarded as an asset if RNs in elder care have training in primary health care and has attended courses on caring for people with dementia, on palliative care and other relevant subjects (Lundström & Ehnfors 2001, Annual reports 2000/2001).

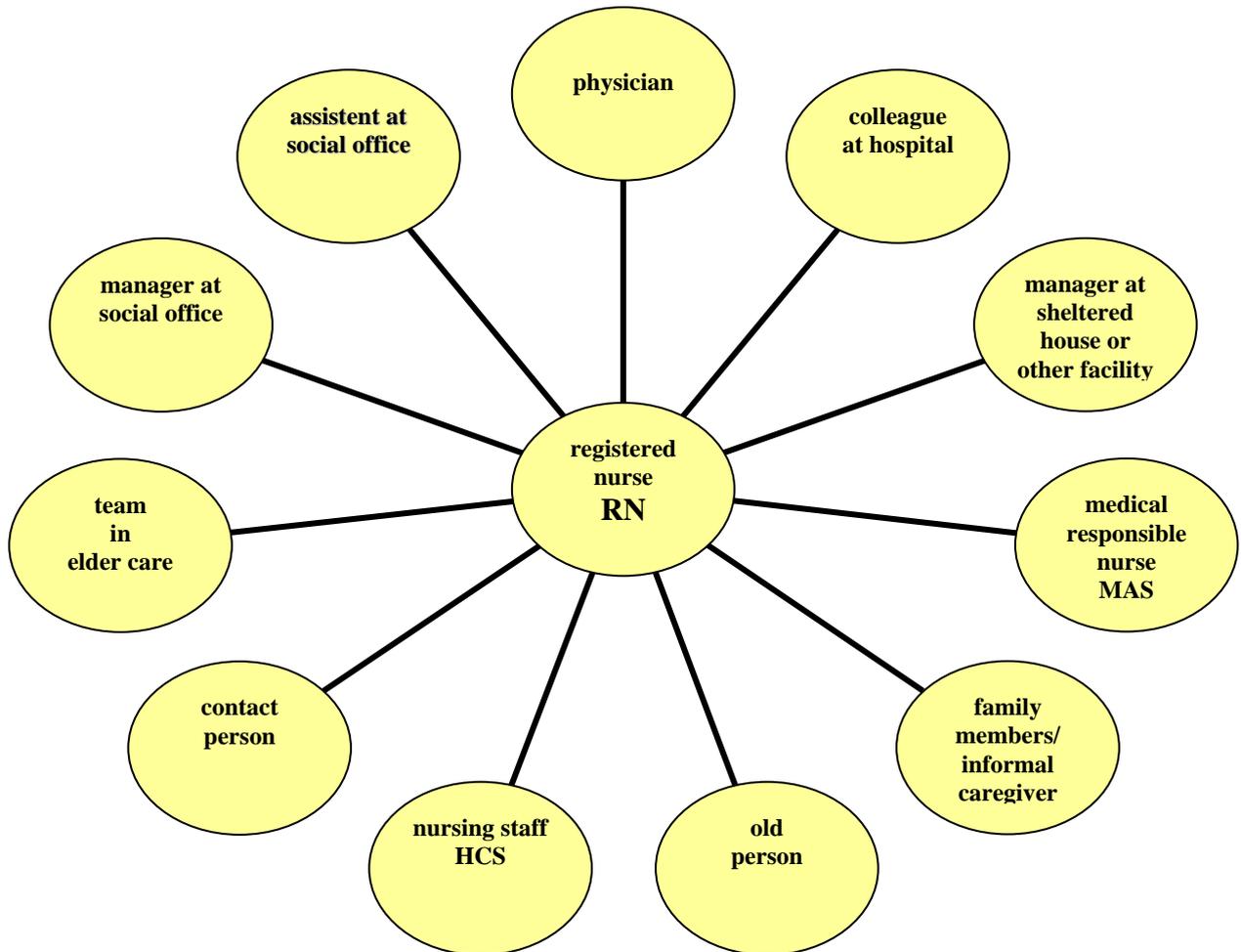


Figure 1. The contact patterns RNs working in community elder care may have in the course of their work. © Karin Weman

The authorities or departments and the people the RN may have contact with during his or her work in providing care for the old are shown in Figure 1. One staff member can belong to one or several circles in the figure.

Family-focused nursing and nursing care

Family-focused nursing is evolving in Sweden (The National Board of health and Welfare 2005e, Saveman & Benzein 2001) influenced by the Calgary model (Wright & Leahey 2000). Family-focused nursing is a large subject field with several different parts of which one is elder care in the communities. The starting point is when a member of the family gets ill, which will then

affect the other family members in various ways. It is therefore most important for the staff in HCS and PHCC, especially for the RN, to take account of the whole family and not just the patient. The concept of work in primary health care and elder care are often influenced by the family care approach (Nolan *et al* 2001, Saveman & Benzein 2001, Nolan *et al* 1996).

Nursing care is developed in caring science (Eriksson 1997) and can be described as three perspectives, *caring nursing*, *nursing care* and *nursing nursing*. *Caring nursing* is when the patient receives unprejudiced care adapted to their suffering and needs, where relationships and communication is the core. *Nursing care* is based on the nursing process, where the patient's needs are in focus and based on illness and diagnosis. *Nursing care* has to be influenced by *caring nursing* to be considered good care. *Nursing nursing* is based on care planning for the patient, where evaluation and reassessment of goals happen continuously (Gustafsson & Fagerberg 2004).

Nursing care can be described and defined in many ways and Travelbee (1971) suggests:

'The purpose of nursing is to assist an individual, family or community to prevent or cope with the experience of illness and suffering and, if necessary, to find meaning in these experiences'. (Travelbee 1971, p. 16)

Nursing care also involves the ability to be sensitive to the situation. The RN must have the ability to step forward when needed and to step back when the old person and the family members can handle the situation themselves. To be an observer and make decisions in a professional way is also a part of caring (The National Board of Health and Welfare 2005d, Watson 1979, Travelbee 1971). In Figure (2) the domains of competence and abilities considered necessary for an RN in community health care are illustrated.

The competence and abilities of an RN in community health care can be describe in four domains (Figure 2), theoretical knowledge, practical skill, social abilities and competence and administration (cf. The National Board of Health and Welfare 2005d, Ronsten *et al* 2005, Tunedal & Fagerberg, 2001)

Figure 2 shows the complexity of different abilities and knowledge that a competent RN ought to have for her/his profession. All these four domains are complementary to each other and have to be fused together, according to the situation and to the person involved. The proportion of each domain can change and none of the domains can be excluded in nursing care (Benner 1984, SFS 1982:763, Watson 1979, Travelbee 1971).

Working as an RN in elder care in the community and as an RN in a hospital ward is in some ways similar and in another way different. Thus what is described in Figure 2 is adequate, irrespective of working place. However, the RN in community elder care works more as a

consultant pedagogue and as leader of project (Kihlgren 2005, Westlund & Larsson 2002, Lundström & Ehnfors, 2001). The immediate contact with the old person can be diminished due to other contacts with personnel and authorities during the course of her work (Figure 1).

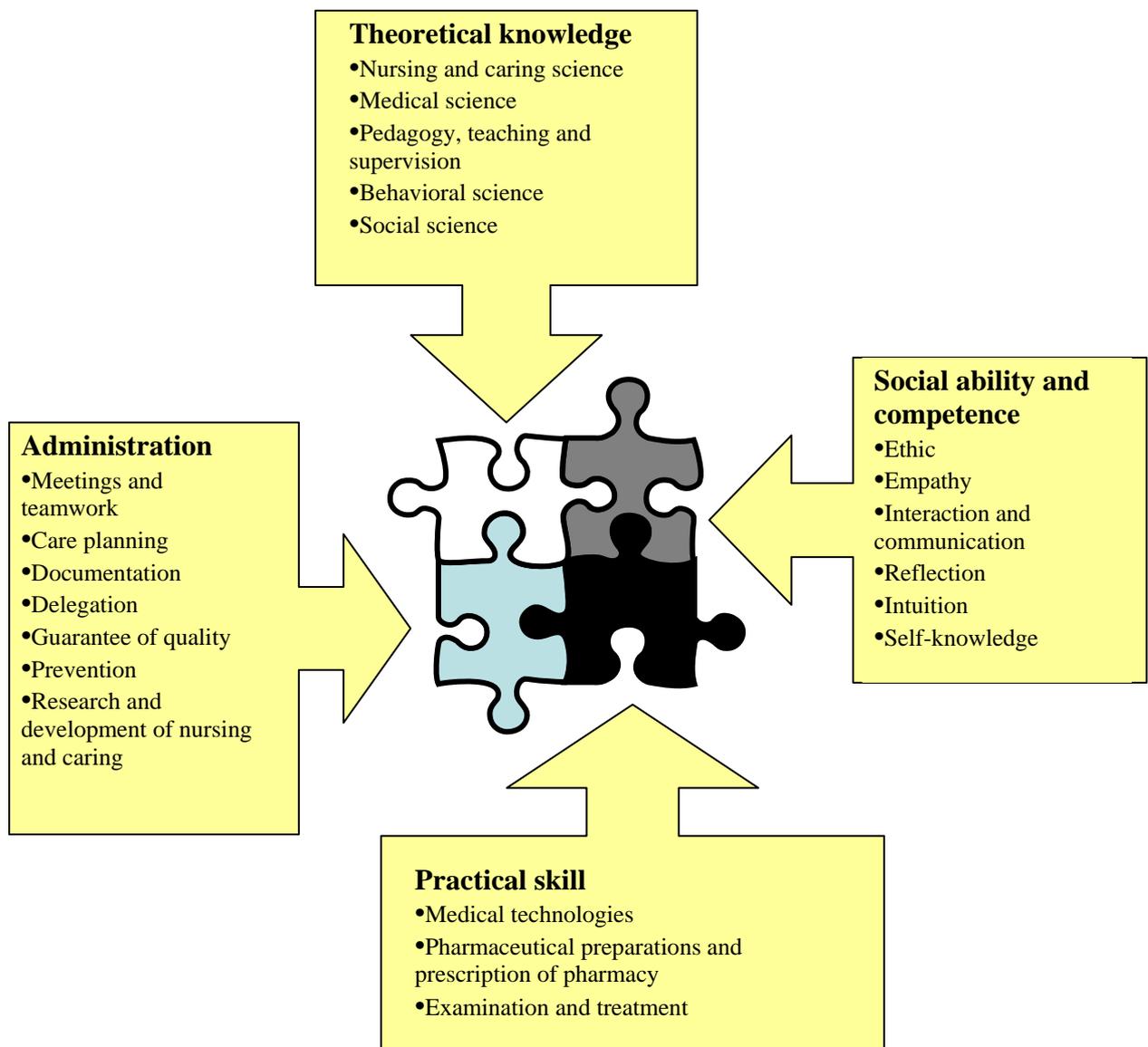


Figure 2 The competence and abilities to be desired for of a RN in community health care.

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RATIONAL FOR STUDIES

The indications for the changes in community elder care is that there will be less economic resources for an increased number of older people. Time in hospital care will be shortened and community health care services will have to provide for a group of older persons with greater medical and caring needs. Family members will be invited to take on a larger part of the basic care for their relatives. Informal care giving and family-focused nursing are increasing in elder care. This will put the RNs' capacity to the test in many ways, such as the requirement to carry out a professional job in the caring situation as a supervisor and in the role of giving support to informal caregivers and family members who are looking after old people. In order to make it better for the old person the challenge for the future is for family members to play their part in the caring situation and to create opportunities for the RNs to co-operate with the family. The RN is a key figure in the organization if the government is to be successful in its intended reforms. With this in mind it was important to gain knowledge of how the RN in community elder care experienced their current working situation.

AIMS

The overall aim of this thesis was to gain knowledge of how Registered Nurses (RN) are able to work together with family members of older people living in community elder care facilities.

In order to achieve this, two studies comprise this thesis and had the following aims:

Study I

The aim of the study was to describe the RNs' views of their working situation in community health care and of co-operation with family members of older people living in nursing homes or similar facilities.

Study II

In order to understand the RNs working situation the aim of the study was to reach a more profound understanding of what RNs' describe influence their co-operation with family members to older persons, living in nursing homes or similar facilities.

METHOD

Design and settings

To achieve the aim a questionnaire incorporating both a qualitative and a quantitative approach was sent to all RNs in a Swedish province with 12 municipalities. The area included one city, provincial towns and rural areas. The intention was to gain an overview at the start of the study with the aim later of illuminating working situations and conditions for RNs in community health care. Some of the results are reported in this thesis.

Elder care in the municipalities included in the study is organized in different ways, depending on the judicial (SFS 1991, SFS 1982:763) and political resolutions taken. The RNs working in the community are mostly based at one of the sheltered housing facilities but then visit and are responsible for the care of the elder living in their ordinary homes and/or different types of caring facilities. The number of staff and colleagues for each RN varied, as well as the number of people they were responsible for. The RNs were on duty both during the day and at night.

Instrument

The questionnaire was prepared using several other questionnaires from other studies on the same subject (Hertzberg & Ekman, 2000, Almberg, 1999, Grafström, 1994). Those studies focused on the working situation for personnel in medical service, or, studies where the focus was on the relation between RNs and family members or other informal caregivers. Some of the questionnaires were used to gain the opinions of the older persons' next of kin regarding the nursing staff working in elder care. Others were aimed at a description of staff working conditions in community health care. In this study the questions were modified, so that RNs' opinions were essential (Rosén & Persson, 1998; SOU 1998:121), in relation to the organization of elder care, the RNs' working conditions and the RNs' views on co-operating with family members. The questionnaire was comprehensive with the aim of gaining as much information as possible, because the data was intended to be a starting point for further studies, not presented in this thesis.

The questionnaire consisted in all of 52 questions and comprised three parts (Table 1). Several alternative replies were possible, *Yes/ no/ do not know*, and statements with Likert scale 1 to 4, indicating *agree/ agree to some extent/ disagree to some extent/disagree*. Four lines were available for written comments for both questions and statements. Comments from six of the

questions, corresponding to the aim of the thesis, were analysed and reported together with the quantitative data in study **I**. Three open-ended questions concerned nurses' experience of options and difficulties in co-operating with family members. An A4 sized paper was provided for each of these questions, for the RNs to write free text on and the answers from these three questions were analysed and reported in study **II**.

Table 1 Construction of the questionnaire.

Backgrounds	Gender Age Working experience Education	Questions 1 – 8	8 multiple-choice questions
Working conditions	Working place Organization of elder care Working situation Working experience	Questions 9- 27	15 questions Yes/No/Do not know 4 questions as statements
Co-operation with family members	Experience of co-operation Approach to family member Professional competence	Questions 28-52	1 multiple-choice question 16 questions Yes/No/Do not know 5 questions as statements 3 open- ended questions

A pilot study of 10 questionnaires was carried out and a modification of some of the questions was made in order to clarify the questions and avoid misunderstandings. The pilot study was also carried out in another province, but the data was not included in this project, and the results have therefore not been included in this thesis.

Participants and data collection

The data collection was planned for both quantitative and qualitative analysis (**I, II**) and it was thus important to have a large number of participants with a variety of experience of elder care in order to gain as broad a picture as possible (Sandelowski & Barroso 2003).

Data collection was conducted during 2000/2001, including two reminders. Names and addresses of RNs were received from staff department in the city and MAS in the small and middle-sized municipalities. All nurses were invited to participate and informed by letter of the

purpose of the study. The questionnaire was distributed to all RNs (N= 314) with permanent positions in elder care in the municipalities and 67 percent (n = 210) answered after two reminders (**I, II**). Other inclusion criteria were not addressed. The questionnaire was returned in a prepaid envelope without any contact with the manager or the MAS in respective municipality.

Participants were aged from 23 to 64 years with a mean average of 46.75 years. Half of the participants were from the city and the other half from middle-sized and small municipalities. About half of the participants had experience of work in elder care of five years or more. The majority of the male nurses worked in the city. Additional participant information is presented in study **I**.

Data analysis

In order to achieve the overall aim a combination of quantitative and qualitative analysis methods was employed.

Study I

All data, except for comments on the question, were used as input in the Statistic Package for Social Sciences (SPSS 10.1 for Windows). Frequency tables, percent distributions and chi-square tests were used for statistical analyses. Statements using the Likert scale and questions with fixed answer alternatives were analyzed using the chi-square test. When data was analyzed using chi-square tests the population was divided into groups for; gender, size of municipality and experience of work in community elder care. The chi-square test was conducted after recoding, since some of the cells involved a low frequency of answers (Körner & Wahlgren 2000, Bland 1995). Comments from six of the questions and statements, where significance was proved or important information given, constituted the base for content analysis. (In Appendix). This in order to give supplementary information corresponding to the statistical results the comments were analyzed by latent content analysis (Berg 1998).

The content analysis process started with rewriting the pencil text verbatim, and all comments were rewritten question-by-question into documents in the computer. A naïve reading of all comments followed this, in order to grasp a sense of the whole. Thereafter the text was divided into meaning units. The meaning units were condensed and formulated as sub themes. The sub themes were elaborated and themes could be presented (**I**). At this time all six questions with comments were analysed as a whole (Berg 1998). When presenting the aspects influencing co-

operation, opinions about working situation and/or the RNs' view of co-operation it was illustrated with category/categories from the latent content analysis. In Table 2 statements from the questionnaire are presented corresponding to match the aim, and 49-153 comments were written for these six questions.

Table 2 Statements in questionnaire where significance was proved or important information given constituted the base for content analysis corresponding to the aim in Study I.

Statements
Content with working situation
Stimulation in working situation
Great pressure and demands from environment
Psychological pressure as RN in elderly care
Important that co-operation takes place between RN and family members
Seeing family members as a resource
Important to facilitate use of informal care givers
Important that family members take care of the elderly persons' interest
Co-operation will be influenced if there is a conflict of interest between RN and family member
Important that family members shows engagement
Asking for better ways to achieve co-operation with families

Study II

The analysis started with rewriting verbatim texts from the three open-ended questions in the questionnaire. The question about difficulties with co-operation was answered by 142 RNs, the question about positive aspects of co-operation was answered by 104 RNs and 107 RNs answered the question about negative aspects of co-operation with family members to the older persons.

The naïve reading was aimed at getting a general impression of the content of all three questions. Step by step the text was divided into meaning units and condensed meanings. Codes, sub-categories and categories were formulated and the themes were created from the categories (Table 1) (Graneheim & Lundman 2004). The categories were compared with the text and with each other in order to assure that the whole content was presented and nothing was missing from the text. The presented categories were all found in the comments from all three questions. This made it possible to bring all three themes, 'problems within the system', 'interaction with

families' and 'caring in nursing work' together, and the result represents the three questions as a whole.

Table 1. Example of analysis of statement

Statement	Meaning unit	Condensed meaning unit	Code	Subcategory	Categories	Theme
When opinions on caring for the old diverge and family members do not understand the situation and have unrealistic expectations and unrealistic hopes.	Unrealistic expectations and hopes in a caring situation	Different opinion	Family members' involvement	Family members supporting the old person	Family members involvement	Interaction with families

Ethical considerations

The Regional Research Ethics committee gave permission for the conduct of this study, D. No: 485/00. The first permission allowed for one reminder to the participants, which was completed with additional approval for two reminders. The RNs were informed in writing that the participation was voluntary, confidentiality was assured and that they could withdraw from the study at any time without explanation. A geographic area with which I had no connection was chosen for the study, in order to make the participants feel comfortable when answering the questionnaire.

RESULTS

Study I

The results showed that nearly half, 46 %, of the RNs were not satisfied with their working situation. No significance was, however, proved with chi-square test concerning the analysis of the part of their working situation. Nurses with more than 5 years of working experience were those who were less satisfied. Nurses felt a psychological pressure in their working environment. The limited organisational, economic and personnel resources adversely affected their ability to work together with family members. Dissatisfaction and frustration was expressed when they could not spend enough time to care for the old people and communicate with their family members. They also expressed the fact that they had no time over to reflect on their work. The nurses also said that it was difficult, when the workload was high, to decide to which family they should give priority, and they asked for better means to help them in this decision process. The RNs felt that they received less understanding and support from managers and colleagues. They expressed dissatisfaction at their manager not having the same education as themselves and believed that there was less understanding for their working situation generally speaking and specifically in situations when difficulties arose with family members.

The majority of RNs believed that it was important to co-operate with family members, emphasising that they could tell the staff important things about their elder relatives. This made staff better able to adapt the care for an older person, especially when he or she was suffering from dementia. The importance of allowing family members to participate was central for the majority of the nurses and significance was demonstrated (Chi- square test = 3.8; df = 1; p- value = 0.050) for gender.

Male nurses believed to a lesser extent that family members were a resource in caring for the old person, but on the other hand male nurses were more convinced of the importance of making it possible for informal caregivers to participate. The RNs held the opinion that family members are more competent and often more demanding nowadays, but also that this could both help and hinder them in their work. The willingness of family members to co-operate was important and significance was found (Chi- square test = 8.8; df = 1; p-value =0.003) for working experience in elder care. If family members were not involved, it would complicate work for the RN, which was explicitly pointed out by the RNs with more than 5 years of experience in elderly care. The nurses believed that it was important for family members to take care of the older persons' interests in different situation, and especially when the old person could not speak for himself or

herself and significance was showed for nurses with more than 5 years of experience (Chi-square test = 6,8; df = 2; p-value =0.009) and for nurses working in small and middle-sized municipalities. (Chi- square test = 6.2; df = 2; p-value=0.046). On the other hand, the RNs remarked that informal care from a family member had to be of the person's own free will and not seen as an obligation. When there were relationship problems or conflicts within a family, the RN usually took the old person's side. Significant differences was found for nurses with working place in large municipality (Chi- square test = 7.2; df = 2; p-value =0.023).

Study II

Three themes emerged from the answers of the three open-ended questions, namely *Problems within the system*, *Interaction with families* and *Caring in nursing work*. In the first theme the categories were *Hindered by the organisation* and *Financial and other resource constraints*. The RNs made clear that they wanted their manager to be a nurse so that he or she would properly understand the working situation for RNs in elder care. Furthermore, the RNs indicated that the changes and frequent reorganisations of elder care in the municipalities had adversely affected their ability to work professionally. The RNs experienced that they did not have enough time to establish contact with the family members and that lack of time also affected the quality of documentation and limited the chances of communicating with colleagues and other staff members. When there was time for more than just the physical aspects of the job the RNs were better able to create individual plans for individual needs and in that way give a high quality of care. Teamwork in elder care is time-consuming and when the RN prioritized teamwork with other professionals the time for co-operation with the family members was reduced. The RNs described the difficulties of getting in touch with the responsible doctor to discuss a subject or get a prescription for the old person. Apart from this, the RN, the doctor and the family members might also have different opinions about what to do in the caring situation. The RNs stated that family members called their knowledge into question and that they acted in a more demanding way than before. When there was a shortage of RNs in elder care nurses were recruited from private staff agencies. The RNs believed that this could pose a dilemma for both the recruited RN and for others involved: the staff, the old person and family members. The opportunity to create possibilities for co-operation would be limited, since a sense of insecurity would exist for as long as temporary staff was involved. RNs said that for night duty co-operation with family members was not of particular importance since they seldom met the families in their work.

In the second theme *Interaction with families* the categories were *Communication*, *Relationships* and *Family members' involvement*. The RNs stated that co-operation with family members of the old was very important for the old person, as the family members could represent the old person's wishes. When family members became involved the staff and the RN were better able to provide professional care. On the other hand, when families did not become involved or when communication was not working within the family, the chances of co-operation between the RN and family members were greatly reduced. Another problem was posed by linguistic deficiencies in the communication between RN and family members. The old person sometimes prevented the RN making contact with a family member. Irrespective of reason, this made it difficult for the RN to inform family members about the old person and changes in his or her state of health. The RNs also stated that they were sometimes unsure of in whose interest a family member was acting. Some of the RNs believed that family members sometimes acted not only on behalf of the old person but also in their own interest. Sometimes family members would not want to be involved when the old person was dying, which RNs saw as problematic, because decision-making became more complicated.

The third theme was *Caring in nursing work* with the categories *Being attentive to the older person*, *Receiving appreciation* and *Feeling of psychological pressure*. The RNs expressed their appreciation of family members' involvement and participation in the care of the old person. An exchange of information about the old person before illness occurred was especially important, since it was then possible to provide better care and understanding for the old person. The RNs stated that family members sometimes called the level of caring and nursing into question and that relatives often had an unrealistic view of how to proceed with caring. The results showed that the RNs experienced that the family members often demanded more medical treatment and advanced care for the old person and wanted to contact the doctor. They did thus not always rely on the RN's judgement and competence even though the RN believed that he or she was responsible for the care of the old person. The RN then felt under psychological pressure. There were also difficulties when the RN had problems reaching family members to give them support. The RN asked for criticism, both positive and negative, because this helped them to adjust their caring work to the situation. They believed that to be seen and appreciated as a nurse strengthened the interaction between the RN and family members, and that, as a result, the energy to manage the situation increased.

METHODOLOGICAL CONSIDERATIONS

A new instrument was constructed from other instruments with the three open-ended questions (II) added, in order to gain more profound knowledge and understanding of what RNs expressed as obstacles and challenges in their work concerning co-operation with family members. Several studies have been conducted on the context of elder care with different approach and perspectives, and validated to a various extent. A common way of validation was to make a pilot study, which also was chosen for the instrument in the present study. Earlier similar studies on the working situation in elder care have been criticized since they have used incomplete instruments and methods and the analysis was too weak (Befve *et al* 1999).

By using a pilot study the questionnaire was tested to investigate if there was any difficulty understanding the questions. Since same questions were used in other studies with other participants the choice was to use the same type of questions without further validation tests. It seemed sufficient at the time of the study to do a pilot study for testing the instrument. Thus making internal consistency has not any justification as the information not will lead to validity in this study. For possibilities to comment the reliability of the instrument the participants should answer the questionnaire twice, which was not possible to arrange due to practical reasons (Polit & Beck 2004).

A possible explanation to the response rate could be that there are several RNs with night duty and in the annual reports it appeared that the organization of elder care has been undergoing reorganization at the same time this data collection was being collected (Annual reports 2000/2001). Moreover another study took place in the same county during data collection for this study. It is possible that the two studies at the same time had a negative influence on the response rate as the RNs could prioritize the other study.

Design and data collection

The participants were divided into groups according to length of work experience, size of municipalities and in gender groups for the statistical analysis. Gender was given prerequisites and five years of experience in elder care was chosen as an appropriate time during which skills could be acquired (Benner 1984). Dividing the municipalities into groups was motivated by the fact that one municipality was a city in which about half of the participants worked. The other half of the participants worked in middle-sized or small municipalities.

In study **I** latent content analysis by Berg (1998) was used for the comments and in study **II** the analysis was made with the step described in Graneheim & Lundman (2004) since it was possible to carry out a more careful and more detailed analysis. It is important to let the aim of the study determine the method. Content analysis is a method to analyse the data systematically and objectively with the interpretation of the underlying meaning of the text, and the analysis means that ‘let the text talk’ and not put meaning that do not exist in the text (Graneheim & Lundman 2004).

Data analysis

Trustworthiness in qualitative methods has a similar meaning as validity and reliability has in quantitative methods. In qualitative methods the concepts, *credibility*, *dependability* and *transferability* are used to describe trustworthiness. Credibility focuses on the design of the study and the collection of data. In this study all kinds of working situation for RN in elder care are represented, which should lend credibility. Dependability includes aspects that in some ways can influence the analysis process and in that way influence the result. The third concept is transferability, how the result can be transferred to other settings. The author can suggest to where the results may be transferred, but it is up to the reader to judge whether the findings can be transferred to other contexts (Graneheim & Lundman, 2004).

For the trustworthiness of the result a co-assessment was made for the analysis in both studies (**I**, **II**). In study **I**, the first and the third authors, and in study **II** the authors read the comments and made an analysis with all steps independent of each other. Thereafter the authors compared their analysis and smaller amendments were made.

Pre-understanding

My professional experience as a nurse, midwife and teacher has made me reflect about what takes place between nurses and family members in caring for other people. The pre-understanding from the context of elder care is mostly from the perspective of being a daughter to my old parents during their illness and death. Being a relative in the combination of being a nurse, midwife and teacher prompted new questions about the co-operation situation. In the analysis I have tried to restrain my personal experience with the intention of being as objective as possible when analysing data. My intention has been to reach a more profound understanding of

what RNs describe influences their co-operation with family members of older persons, which hopefully can be used in community elder care.

REFLECTIONS OF THE RESULTS

Results from both studies (**I, II**) pointed out the RNs' view of the importance of involvement in the co-operation from family members. Moreover, half of the RNs expressed that their job satisfaction was low and that they felt great demands and pressure from the environment in their work. The RN is in contact with a great number of people (Figure 1) and this complexity (Figure 2) in the profession is important to have in mind as the RN has a great responsibility for providing good care to people (cf. Watson 1979). The results are presented by first discussing the organization seen by the RNs. After that the discussion are about communication, being caring in nursing work and the use of family- focused nursing care is discussed. At the end a gender perspective is given.

Organization

The results (**I, II**) indicated that the organization influenced RNs in community elder care in different ways, both their job satisfaction and the family co-operation. The great demands and pressure from the environment in their work was held mostly by RNs with long experiences (**I, II**) and their job satisfaction was low (**I**). The RNs in community elder care has to work alone to a great extent (Westerlund & Larsson 2002). Feelings of physiological pressure and experiences of lack of time are demonstrated (**I, II**). The result also showed that RNs with long experiences did not get the same support from the manager and colleagues as the less experience RNs got (**I**). The importance of having a manager who knows what it is like to work as an RN in elder care seems to be central for the majority of nurses in this study. Similar results are shown in other studies (Kihlgren 2005, Westlund & Larsson 2002, Kihlgren *et.al* 2003, Lundström & Ehnfors 2001, Tunedal & Fagerberg 2001).

The indication from half of the nurses that they did not feel satisfaction in their work (**I, II**) is an interesting and important result as it can have consequences for the future, like nurses leave

for other positions (cf. Gardulf *et al* 2005, Tunedal & Fagerberg 2001, Sjöberg & Sverke 2000). The salary level and lack of support from manager are declared as causes. The same result was found in studies concerning RNs work at hospital wards (Fochsen *et.al* 2005, Gardulf *et.al.* 2005). It is important for the communities to take these facts in consideration when creating good working conditions for the RNs to work in the elder care in the future.

The result (**I, II**) indicated a high workload for the RNs. Rowe and Sherlock (2005) highlight the risk for burn out when work load is too high. Results in that study showed that the verbal abuse between nurses often occurs. There is an potential risk for transferring this experience into more stress, less satisfaction with the job and perhaps provide a substandard quality of care to the old persons. Forsgårde *et al* (2000) highlights the importance of being accepted as colleague and that communication leads to knowledge and development. In order to get the RNs to feel safe and secure in his or hers work Gustafsson & Fagerberg (2004) describe reflection as a tool for professional development. The complexity of knowledge and abilities that an RN shall have for working as a nurse the reflection of his or her work will help to get more understanding about the nursing care and about self-knowledge. Reflection takes time and this must be taken into consideration when organizing nurse' and community elder care.

Education and guidance can increase job satisfaction among staff in elder care (Carter 2003, Tunedal & Fagerberg 2001). Independent of experience and age of the RN it is important to continuously give support and further training with different types of courses or educations (Häggström *et al.* 2005, Tunedal & Fagerberg 2001, Annual reports 2000/2001) This is a way of confirming and giving appreciation to the RNs something asked for in study **II**. The communities have to educate the staff members and possibility also the family members when they act as informal caregivers. This could be prevention for misunderstanding, burn out, neglecting and abuse of the elder (Hardin & Kahn-Hudson 2005).

Results from both studies (**I, II**) pointed out the importance of involvement in the co-operation from family members. The family members know the old person best and the staff needs this information especially when the old person is suffering from dementia (Hellström, 2005). A collaborative relationship between the RN and the family member towards a common goal result in confidence in nursing care and job satisfaction (Ward-Griffin *et al* 2003, Luker *et al* 2000). The nurses stated it was important to get time for knowing the older person (**I**) findings in line with Coleman (1999) and Öberg (1997). To get to know the person will lead to a better quality of the care and to better understand the person's needs (Ingersoll- Dayton *et al* 2003). This will increase the importance of communication.

Communication

The result in these two studies (**I, II**) indicates that there are sometimes difficulties with the communication between the RN and the family members. Communication demands good relationship within the family and between the nurses and the family (Ward-Griffin *et al* 2003). Relationship can be described 'as an alliance based on communication and mutual respect' (Ward-Griffin 2001, p. 65). To establish a relationship takes time and this time seem to fail for RN in community elder care (**I, II**). By taking the time at the beginning of co-operation the RN can create a trustful climate both for the old person and the family members. This will be of great value when the family members and the RN have to co-operate under great pressure, for instances in terminal care or when illness progress (cf. Almberg 1999, Andershed 1998). Furthermore, it was important for the RN to get support from other RNs when they wanted (**I**) and discussing with colleagues who were familiar with the situation they felt support (**I**) which also founded in Tunedal & Fagerberg (2001)

In study **II** the RNs expressed that sometimes the family members avoid contact and can not participate in the care for a relative at the end of life. Luker *et al* (2000) suggests that it is even more difficult to create good relationship with the family members when the patient is at the end of life. In study **II** the RN also pointed out that they found it difficult to handle the situation when the old persons did not want the family members to know about the current situation. Öhman & Söderberg (2004) meant that when RNs have possibility to build up a relationship with the old person and the family the RNs more easily could get entry. In these situations the RNs pedagogical knowledge will be challenged. Unsolved conflicts within the family are also a source of strain in the care giving relationship (Hudson *et al* 2004, Ward-Griffin *et al* 2003, Plowfield *et al* 2000) and these influenced the RNs possibilities to provide care as well (**I, II**).

The communication problem might depend on conflicts within the family (**I**) or linguistic problems or culture clashes (**II**). Luker *et.al.* (2000) pointed out the difficulties that will appear when there are language barriers between the RN and the patient and/or the family members. Studies describing the situation of older immigrants in Sweden (Heikkilä 2004, Torres 2001, Emami 2000, Ekman 1993) have shed light on the complicated situation for older immigrants with risk of becoming more isolated and having a worse health condition compared to the general Swedish population. Difficulties to learn a new language, adapt a new culture and lifestyles are facts that complicate life for this group of people. The dilemma when there are difficulties to understand each other is mutual for RN and the old.

Being caring in nursing work

Watson (1979) indicates the importance of a human – to- human relationship in caring for another person. The findings (**I, II**) indicate that the RNs working situation influence the possibilities for co-operation with family members. The RN has in her job a unique position when she is a guest in private homes and thereby can reach a close relationship with the old person, thus hold a protection position of the old person and the family (Öhman & Söderberg 2004).

In study **II** the RN expressed their frustration about what to do when the old person do not want family members to know about illness or other important issues. Caring for a dying person is demanding and in many studies the support from professional is asked for (Hudson *et al* 2004). The RNs in community health care shall support the family members. The information and practical support to the caregiver can both be provided and inhibited depending on different barriers. In some situation the old and/or the family member avoid talking about dying or the end of life and then it will be even more difficult for the RN to act. The decision what to do will be difficult for the RN. Luker *et al* (2000) pointed out the difficulty of working in a person's home with limited possibility for being alone with the patient. The family members are around the whole time, which can influence the caring situation for the nurse. When providing care in a person's private home the RN is a guest and when care is provided at a hospital ward the old person will be the guest. This will influence the co-operations situation. The one how are at 'home ground' will automatically be in a leading position. The RN is seen as an 'expert' caregiver while the family members do not have the position and the situation will automatically give the RN advantage. When there is an imbalance of power the RNs could use different types of strategies to reduce the family members possibility to influence the on the caring situation (Rundqvist 2004, Ward-Griffin *et al* 2003).

In study **II** the category '*Being attentive to the older person*' arises. In the nursing care the RN have the 'holistic view' of the old person's situation the possibilities to create a good situation for the old person and for the family members (Watson 1979, Travelbee 1971). In the caring art it is important to be attentive to the old person and try to understand what the person want (cf. Travelbee 1971).

Family- focused nursing care

The results in studies **I** and **II** indicate that the RNs are worried about the family members who took a great responsibility for caring of the old. The RNs pronounced that the engagement from family members were important but has to be taken on free will and not as an obligation.

The RNs indicated that sometimes the family members are holding another opinion about the situation for the old person than the RN did (**II**) (cf. Rose *et al* 2000). In family-focused nursing one of the central issues in caring situation is that the persons involved in the situation has their own 'beliefs', so called 'core beliefs', why the situation has arisen and how to act for getting well or reduce consequences. The 'core beliefs' spring from experiences and values that the person has about life, death, illness, suffering, healing and health. The 'core beliefs' are important for the RN to bear in mind in her contact with the old persons and the family members. The RN have to reflect about how and why an old person and the family member act in an certain situation and why the patient or family member does not seem to take notice about instruction and information given (Wright *et al* 1996). It is also important that the RN reflect on his or her own 'beliefs' as it will influence the way to solve a situation or problem (Benzein *et al* 2004). In study **I** and **II** the RNs' indirectly talked about their own 'beliefs'. By using family – focused nursing the RN will get possibilities not just to focus on the old but also take the family members into the arena as the whole family is concerned when illness occurs. To achieve the goal of family-focused nursing it is important for the RN to establish a relationship with the old person and the family members (Wright & Leahey 2000).

Better ways to achieve co-operation with family members were asked for and methods in order to make it easier to prioritize their action for the family members (**I**). The result in study **II** showed that the RNs found it difficult to know which person to give priority to. In order to facilitate for the RN in their work, e.g. conflicts within family, a method called for '15-minute (or shorter) family interview' developed and described by Wright & Leahey (2000). The interview is aimed to let the person describe what issue is the most important to act for. During the interview a 'genogram', a map of the network around the old person that will clarify the strength and weakness in interaction and supporting each other in the family. By doing the 'genogram' the RN can get help to prioritize within the family and between families best in need (Wright & Leahey 2000). The RNs also expressed that they did not have enough time for co-operation and talking with the family members (**I, II**) therefore a 'genogram' might help them.

Gender perspective

Male nurses in study **I** were less interested in taking the family members services for the old into consideration. They did not see the family members as a partner for co-operation to the same extent as the female RNs did. On the other hand they wanted to facilitate for the family member to a greater extent than the female nurses. Female family members provide the majority of care giving support to elders (Ward-Griffin *et al* 2003, Winqvist 1999). Söderhamn, Lindencrona & Gustavsson (2001) showed that male nurses and male nursing student held more negative feelings towards older people than female nurses and student did. There was not any difference in attitudes towards old people between nurses working in hospital compared to nurses working in the community in that study. The female RNs in study **I** and **II** can perhaps recognize themselves from the situation to be a family member which can explain some of the results as informal care giving shall be on a person's own free will. The RNs in study **I** had a mean age of 46.75 years with range of 9.93 which indicate that they perhaps were in the same age as the family members described as 'the sandwich generation' by Seaward (1999). 'The sandwich generation' is an expression covering the position of being in between of all. The situation for women is complex and the demands are great from many in their environment. Seaward (1999) meant that middle-aged females are in a position for giving care to aging parent, supporting children and perhaps grandchildren parallel with gainful employment. Can female RNs to a higher extent make parallels of their own situation in taking care of other persons and is it easier for female RNs to recognize the situation and give support to the family member? The male RNs (**I**) had a different meaning of how to see the family members in co-operating situation and perhaps it has its ground in the fact that men take part of care giving to a lesser extent than as female do? Further studies are needed to clarify the gender perspective of caring and co-operation, which the two studies **I**, **II** can not manage.

Conclusions

In study **I** the nurses expressed the opinion that it is important that family members take the old person's side and are concerned about the care given to the old person. The RNs do not give any reason why they held that opinion, and it is a question for further research.

The development of community elder care will put increasing demands on the RNs in community elder care in the future and there is a need for further support and guidance, to allow

the RN to see both the whole and the separate parts, and have the ability to bring it all together. Her working situation involves both working alone and being a part of a team.

Informal care giving is also expected to increase as the elder population increases and by that the registered nurse will be even more important in community elder care as more persons are dependent on her competence. Conclusions drawn imply that the RN in community elder care is dependent on the organization of elder care and the organization is dependent on RNs competence.

IMPLICATIONS

The results showed that a large number of RNs did not experience satisfaction in their work in elder care for various reasons, and therefore further investigation into the scale of job satisfaction or other instruments is needed.

Further studies should be done on the gender perspective and its possible impact on how family members are respected by male and female nurses.

There is also another interesting issue to take into consideration, the perspective of family ties and how this influences their feeling of 'responsibility' for each other during lifetime. Who cares for whom?

A study on how older immigrants' needs' are to be met would also be desirable.

APPENDIX

Question	
21	Are there documented routines about when and how contacts with relatives / close friends should be done when a person in the elder care community gets sick or dies?
26	Answer the following questions regarding the management at your work Do you consider that your manager/boss..... ...make clear demands about what co-workers should do ...is reachable when you need help or support ...encourages others to bring necessary changes and improvements. ...shows understanding about your working conditions ...have good knowledge of the work base
34.	Do you think relatives/close friends should be given the possibility to take a bigger part in the care of the old in the community setting?
36.	Do you feel that relatives/close friends have changed their attitude in the way they collaborate with you?
39	Do you think that collaboration with relatives/close friends is going to increase or decrease, in respect to the development of care of the old?
46	Is there a difference for you to collaborate with relatives/close friends if the patient is suffering from dementia?

SVENSK SAMMANFATTNING

Populärvetenskaplig sammanfattning på svenska (Summary in Swedish)

Sjuksköterskors samverkan med anhöriga till de äldre inom kommunal äldreomsorg – en utmaning för framtiden.

Antalet äldre i Sverige kommer att öka under kommande år, i synnerhet gruppen 80 år och äldre. De äldre har ofta en komplicerad sjukdomsbild med behov av medicinsk vård, omvårdnad och rehabilitering. I framtiden kommer också antalet äldre med invandrarbakgrund att öka vilket kommer att medföra att det ställs andra krav på den kommunala äldreomsorgen än idag. Vårdtiden på sjukhusen har förkortats och mer avancerad sjukvård förläggs till kommunal hälso- och sjukvård. De ekonomiska resurserna i samhället skall fördelas på fler individer. Utvecklingen har i Sverige de senaste åren varit att erbjuda hemsjukvård till äldre som är i behov av det. Flera studier visar att det ökar kvaliteten för den äldre att få tillbringa sin vårdtid i hemmet istället för på särskilt boende eller motsvarande. Intentionerna från regeringen är att fler äldre skall vårdas i sitt hem till livets och att anhöriga måste ta ett större omvårdnadsansvar för sina äldre i framtiden.

Sjuksköterskan har inom kommunal äldreomsorg har ett avancerat arbete med ansvar för multisjuka äldre personer. Med kompetens inom områden såsom medicinsk vetenskap, omvårdnadsvetenskap, beteendevetenskap och pedagogisk kunskap har hon i sin profession en speciell funktion att analysera och åtgärda situationer som uppstår för den äldre och till viss mån de anhöriga. Arbetssituationen för sjuksköterskor inom kommunal äldreomsorg är komplex och många aspekter påverkar hennes möjligheter att arbeta professionellt.

Familjefokuserad omvårdnad är ett arbetssätt som är under uppbyggnad i Sverige och där grundtanken är den att om någon i en familj blir sjuk påverkas hela familjen av det. Genom att arbeta familjefokuserat kan den äldre och dennes familj ses som en helhet och få hjälp och stöd av sjuksköterskan för att förhindra försämring och lindra förloppet av sjukdom.

Avhandlingsarbetet syftade till att få kunskap om sjuksköterskors möjligheter att utveckla samverkan med anhöriga till de äldre som är i behov av kommunal äldreomsorg.

En enkät distribuerades ut till sjuksköterskor med anställning inom kommunal äldreomsorg i ett län. Två tredjedelar av de tillfrågade svarade på enkäten som innehöll frågor om sjuksköterskors arbetssituation och deras erfarenhet av samverkan med anhöriga till de äldre. Bearbetning av svaren skedde både med statistisk och med innehållsanalys.

Delarbete **I** syftade till att beskriva hur sjuksköterskors upplevde sin arbetssituation och hur deras erfarenhet av samverkan med anhöriga till de äldre kunde te sig.

Resultatet från delarbete **I** visade att nästan hälften av sjuksköterskorna var missnöjda med sin arbetssituation och det är framför allt sjuksköterskor med mer än 5 års erfarenhet. Sjuksköterskor med kortare tids arbetserfarenhet inom kommunal äldreomsorg fick mer stöd av chefen är de med längre tids erfarenhet. Samtliga sjuksköterskor ansåg att det var viktigt att anhöriga visade engagemang för sina äldre anhöriga. Om den äldre inte kunde föra sin egen talan var det viktigt att anhöriga trädde in och gjorde det. Samverkan försvårades om det rådde konflikter inom den äldres familj och om det vara svårt att kommunicera med anhöriga på grund av språksvårigheter. Metoder efterfrågades för att bättre kunna veta vem i familjen eller vilken av familjerna som skulle prioriteras för att möta de olika behoven av vård. Resultatet visade också att anhöriga ibland önskade en mer avancerad vård för den äldre än vad sjuksköterskan bedömde vara adekvat. Manliga sjuksköterskor såg inte anhöriga som en resurs i vården i lika stor utsträckning som de kvinnliga sjuksköterskorna gjorde.

Delarbete **II** syftade till att få kunskap om vad sjuksköterskorna fann positivt, negativt och svårt i sitt samarbete med anhöriga.

Resultatet från delarbete **II** visade att sjuksköterskorna upplevde att organisationen i äldreomsorgen kunde hindra dem i deras arbete. Minskade resurser både ekonomiskt och tidsmässigt var en nackdel och en känsla av otillräcklighet i arbetet uppstod. I arbetet måste sjuksköterskan ha kontakt med andra personer i vårdteamet vilket var viktigt men tidskrävande. En del av sjuksköterskorna uttalade också att de upplevde det problematiskt när ansvarig läkare inte fanns att snabbt tillgå för rådgivning och beslut. Några sjuksköterskor önskade att få mer stöd från ansvarig chef eller enhetschef. Flertalet påpekade att det vara viktigt att ha en chef som var sjuksköterska och som visste vad arbetet som sjuksköterska inom äldreomsorgen innebar. Samverkan med anhöriga var viktigt och många påpekade att utan anhörigas insatser skulle detta vara svårt att räkna till. Speciellt viktigt var samverkan när den äldre var demenssjuk eftersom anhöriga då kunde ge en beskrivning av den äldres tidigare liv vilket kunde hjälpa personalen i omvårdnadsarbetet. För att förtroende och tillit skall kunna skapas behöver sjuksköterskan tid att

etablera kontakt med de anhöriga till den äldre. Denna tid fanns inte alltid att tillgå och sjuksköterskorna uttalade att de kände en frustration när de inte kunde utföra sitt arbete på det sätt de ville.

Svårigheter kunde också uppstå när det var språkförbistringar mellan sjuksköterskan och den äldre och/ eller de anhöriga. Det var också problematiskt när anhöriga inte litade på sjuksköterskan utan krävde medicinska insatser som inte var ordinerade av ansvarig läkare.

I diskussionen lyfts problematiken hur organisationen inom kommunal äldreomsorg påverkar sjuksköterskans arbete. Vidare belyses kommunikationens betydelse för att känna arbetstillfredsställelse och för att kunna samarbeta väl med anhöriga till de äldre.

Slutsats

Med tanke på de ökade kraven som ställs på personal inom kommunal äldre omsorg i framtiden är det väsentligt att ge sjuksköterskorna stöd och handledning. Brist på stöd från ledningen och minskande resurser utgör allvarliga signaler, och risken att förlora kompetenta sjuksköterskor i framtiden är stor.

Mycket av arbetstiden är ensamarbete i den äldres hem och ibland tillsammans med familjen. Detta ställer krav på sjuksköterskan förmåga att använda kunskap av olika slag och att vara följsam mot den äldre och dennes familj.

Sjuksköterskan skall ha förmåga att se helheten och dess delar i ett i sammanhang. Informella vårdgivare förväntas öka och deras behov av sjuksköterskan stöd och omsorg blir då också efterfrågat i större omfattning än idag. Generellt ansåg sjuksköterskorna att det var och är av stor vikt att underlätta för anhöriga att ta del av omsorgen av den äldre men det poängteras att det bör ske på frivillig basis.

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